Virginia Department of
HUMAN RESOURCE
MANAGEMENT

Commonwealth of Virginia Retiree Health Benefits Program

Annual Premium Rate Notification Materials for Medicare-Eligible Participants

This Rate Notification Booklet includes:

Also enclosed:

- **Member Handbook Prescription Drug Insert (only for existing participants in this coverage—please discard if you enroll in Medical-Only coverage)**
- **Member Handbook Dental/Vision Insert amendment (only for existing participants in this coverage—please discard if you cancel this coverage)**

DISTRIBUTION: ***Only Enrollees (Retirees, Survivors and Long-Term Disability Participants) will receive this package. Medicare-eligible covered family members will not receive annual premium rate notification materials directly, even if they have individual ID numbers. This means that Enrollees must share this information with their Medicare-eligible covered family members. Only Enrollees can request coverage changes for covered family members. If you are an Enrollee who is not eligible for Medicare but you are covering a Medicare-eligible family member, you are receiving this package for the Medicare-eligible family member whom you cover.***

COMMONWEALTH OF VIRGINIA

DEPARTMENT OF HUMAN RESOURCE MANAGEMENT

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To: **State Retiree Health Benefits Program Enrollees Eligible for Medicare or Enrollees who cover Medicare-Eligible Family Members**

From: **Office of State and Local Health Benefits Programs**

Date: **October 29, 2013**

Important Information Regarding Your Health Benefits

This notification booklet includes information about coverage for Medicare-eligible participants in 2014. Be sure to read these materials carefully to ensure that you understand your options.

Receipt of benefit-specific information in this package does not guarantee those benefits. In family groups with multiple Medicare-eligible family members, Enrollees will receive information about all plans within their family group. (For example, if you are in a plan without dental and vision coverage, but you are covering a family member in a plan that includes dental and vision, you will receive dental and vision information.)

Your 2014 Premium Cost

- ***How much is my health plan premium for 2014?***

Monthly premiums for all plans are provided on page two. Increased costs for the prescription drug benefit and the Medicare supplemental expenses under Option II and particularly Option I resulted in increased premiums for all plans except the medical-only plans.

The full impact of the premium increases has been adjusted for 2014 based on previous overfunding of the Medicare-coordinating plans as reported by the Auditor of Public Accounts in October 2011 and maintained to date. After actuarial review to ensure that there is adequate funding for the 2014 program, including reserves to cover trend increases and incurred but not reported costs, fund assets were reduced by $6 million,

which was used to reduce 2014 premiums. The chart below reflects the resulting monthly premium rates for 2014. Continuing plan cost increases in future years may result in higher premium increases since a similar adjustment may not be available.

2014 Premiums

Plan – Single Membership	2013 Premium	2014 Premium Effective 1/1/14	% Change
Advantage 65	**$237**	**$247**	**4.2%**
Advantage 65 + Dental/Vision	**$271**	**$279**	**3.0%**
Medicare Complementary/Option I	**$262**	**$287**	**9.5%**
Medicare Supplemental/Option II	**$304**	**$316**	**3.9%**
Option II + Dental/Vision	**$338**	**$348**	**3.0%**
Advantage 65—Medical Only	**$139**	**$131**	**-5.8%**
Advantage 65—Medical Only + Dental/Vision	**$173**	**$164**	**-5.2%**

All State Medicare-coordinating plan medical and vision benefits are administered by Anthem Blue Cross and Blue Shield. For plans that include prescription drug coverage (all but the Advantage 65—Medical Only Plans), the drug benefit is administered by Express Scripts and is an enhanced Medicare Part D plan. Dental benefits are administered by Delta Dental of Virginia.

Remember—you have other options for Medicare-coordinating coverage including enrolling in a Medicare Advantage plan or getting your Medicare prescription drug coverage outside of the state program. Even if you decide to keep your medical supplemental coverage through the state program, you are encouraged to review all available Medicare Part D (prescription drug coverage) options to ensure that you select the best plan to meet your individual needs. Page seven of this booklet includes resources to help you review your other choices (see "*Is the state program's prescription drug coverage the best plan for me?").*

▪ ***Attention Option I and Option II Enrollees!***

This annual rate notification is a great reminder to review your benefit choices. Option I and Option II participants can change their Medicare supplemental coverage in the state program to an Advantage 65 plan prospectively at any time.

Medicare Complementary – Option I Plan

Due to the decreasing size and increasing claim costs of the Option I Plan, its premium is now higher than the Advantage 65 with Dental and Vision Plan. Also, the Advantage 65 with Dental and Vision Plan provides some additional benefits not covered under the Option I Plan:

- It reduces the $1,000 deductible for Part B services to just the Medicare Part B deductible ($147 in 2013).
- It includes coverage for designated out-of-country major medical services.
- It includes coverage for specified at-home recovery care.

The routine dental/vision and the prescription drug plans are the same under both Advantage 65 with Dental and Vision and Option I.

Option I participants can move to either an Advantage 65 or Option II Plan prospectively at any time. Moving to the Advantage 65 Plan with Dental and Vision will reduce your monthly premium by $8 per month while increasing your benefits as explained above.

Because the increased 2014 premium cost for the Option I Plan has resulted in a higher premium for less coverage in comparison to the Advantage 65 plans, the Option I Plan may be discontinued in the future. Consider making a plan change now.

Medicare Supplemental – Option II Plan

Option II enrollees can reduce their premium if they move to an Advantage 65 Plan. Use your Medicare-Coordinating Plans Member Handbook to compare plan provisions. If you are not using benefits that are unique to Option II, or the benefits you are receiving do not justify the premium difference, consider moving to an Advantage 65 plan.

The Medicare-Coordinating Plans Member Handbook is available online at www.dhrm.virginia.gov and will allow you to compare Option I, Option II and Advantage 65 Plans so that you can choose the plan that works best for you. Differences in plan provisions can easily be identified in each benefits section, as well as in the coverage charts at the front of the handbook.

- ***If I qualify for "Extra Help" with my prescription drug costs, how will my premium be affected?***

If you have qualified through the Social Security Administration for "Extra Help" paying the cost of your Medicare Part D coverage and you are approved for enrollment in the state program, your premium will be reduced for each month you are approved for the subsidy. You will receive confirmation of your premium reduction from Express Scripts Medicare as a part of your Annual Notice of Changes (or at the time of your approval). More information about "Extra Help" (also known as the low income subsidy or LIS) will be included in your Express Scripts Medicare Evidence of Coverage. Following are the "Extra Help" reductions for 2014:

Subsidy Level	Monthly Premium Reduction
1-6	$31
7	$23
8	$16
9	$8

Participants who have qualified for "Extra Help" are encouraged to explore other Medicare Part D plan options outside of the state program. While your state program premium is reduced due to your subsidy, beneficiaries are still paying the remaining premium for an enhanced Medicare Part D benefit that may not be providing additional coverage. The Medicare web site (www.medicare.gov) or 1-800-MEDICARE can provide a summary of other plans and benefits that are available to you, including plans with minimal or no premium cost.

If you would like more information about "Extra Help" (the low income subsidy), contact the Social Security Administration at 800-772-1213.

▪ ***Can my income affect the cost of Medicare Part D?***

Beneficiaries with incomes above a level set by Medicare may have to pay a higher cost for Part D prescription drug coverage. You will be notified by Social Security if this applies to you, and any income-related adjustment will be collected through your Social Security or equivalent benefit and not as a part of your Commonwealth of Virginia Retiree Health Benefits Program premium. Your *"Medicare and You 2014"* publication has more information about the cost of Medicare Part D and Part B.

▪ ***When will I begin paying my new 2014 premium?***

For participants whose premiums are deducted from a VRS retirement benefit, the new January 2014 premium will be deducted from the February retirement benefit payment. If a premium increase means that your retirement benefit is no longer enough to support the deduction, you will be moved to direct billing from Anthem Blue Cross and Blue Shield. It is important to note that direct billing is mailed before the coverage month while deduction occurs at the end of the coverage month.

For those who already pay through direct billing, the new premium will be billed in December. If you have requested a change in coverage, the premium change may take place later depending on the date of your request. For those who are paying through automatic bank draft, your first deduction in the new premium amount will take place in your January draft.

Your 2014 Benefits

▪ ***Will my medical benefits change for 2014?***

The Medicare supplemental benefit under any Advantage 65 Plan, Medicare Complementary/Option I and Medicare Supplemental/Option II will not change for 2014.

Consult your "*Medicare and You 2014"* publication to determine if there are any changes to your primary Medicare coverage for 2014.

▪ ***Will my dental and vision benefits change for 2014?***

Effective January 1, 2014, participants enrolled in the routine dental/vision option can receive a routine eye exam, frames and lenses once every plan year (January 1 through December 31) instead of once every 12 months. This will provide more flexibility for using your vision benefit.

There are no changes to the optional routine dental benefit for 2014.

▪ ***Will my prescription drug benefits change for 2014?***

If you choose to maintain prescription drug coverage under the state program's enhanced Medicare Part D plan (Express Scripts Medicare), be sure to review the following updates for 2014:

Formulary/Drug List (your list of covered drugs) – As a part of your Annual Notice of Changes (ANOC), which you will receive separately, Express Scripts Medicare will provide all participants with a new formulary (your list of covered drugs) for 2014. It is important to check your formulary to see if any of the drugs you are currently taking are no longer covered in 2014, have changed copayment/coinsurance tiers, or have any new coverage restrictions. If you are taking a drug that is not currently covered, check to see if it is covered for 2014. If you are taking a drug that will experience a negative formulary change (such as moving to a higher cost-sharing tier or being removed from the formulary), you will also be notified by Express Scripts Medicare separately before the end of 2013. If you are unable to find your drugs in your new formulary, contact Express Scripts Medicare at 1-800-572-4098 starting November 1 for assistance. The Commonwealth of Virginia Retiree Health Benefits Program's Medicare Part D plan does not normally cover drugs that are excluded by Medicare.

Starting January 1, 2014, you may also go to www.Express-Scripts.com for complete formulary information. Registration is required if you have not done so previously.

Certain changes can be made to the formulary during the year, as approved by Medicare, such as adding to or removing drugs from the formulary; adding prior authorizations, quantity limits and/or step therapy restrictions on a drug; or, moving a drug to a higher or lower cost-sharing tier. Generally, however, if drugs are removed, coverage limitations are imposed, or a drug is moved to a higher cost-sharing tier during the year (after January 1) and you were already taking the drug on January 1, you will be permitted to continue taking that drug at the same level of cost-sharing for the remainder of the plan year. Exceptions would include drugs replaced with generic equivalents or changes as a result of new information on a drug's safety or effectiveness. In those cases, you may be affected by the change during the plan year. Your formulary includes additional information regarding changes. The Centers for Medicare and Medicaid Services has reviewed and approved your formulary.

Four Coverage Stages

There are some changes to this plan's coverage stages for 2014 as described below by tier. Be sure to review the limits and benefits of each stage so that you understand your coverage.

Deductible Stage – Your annual outpatient prescription drug deductible will decrease to **$310** in 2014. This means that you will pay the full cost of any covered brand-name drug until you have paid $310 out-of-pocket. Covered generics continue to be excluded from any deductible.

Initial Coverage Stage –There are no changes in copayments and coinsurance for each cost-sharing tier for 2014. Once your deductible has been met for covered brand drugs (and immediately for covered generics), your copayments/coinsurance will remain as follows until your total covered drug cost reaches $2,850.

Initial Coverage Stage - Covered Tier 1 (generic) Drugs	2014 Copayment
Per one-month (up to 34-day) supply at a retail network pharmacy	$7
Per up to a 90-day supply through the home delivery service	$7

Initial Coverage Stage - Covered Tier 2 (preferred brand) Drugs	2014 Copayment
Per one-month (up to 34-day) supply at a retail network pharmacy	$25
Per up to a 90-day supply through the home delivery service	$50

Initial Coverage Stage - Covered Tier 3 (non-preferred brand) Drugs	2014 Coinsurance
Per one-month (up to 34-day) supply at a retail network pharmacy	You pay 75%
Per up to a 90-day supply through the home delivery service	You pay 75%

Initial Coverage Stage - Covered Tier 4 (specialty) Drugs	2014 Coinsurance
Per one-month (up to 34-day) supply at a retail network pharmacy	You pay 25%
Per up to a 90-day supply through the home delivery service	You pay 25%

NEW – Daily Cost Sharing

Often, when you get a new prescription filled, you get a month's supply (up to 34 days) of a covered drug. However, there may be times when you want your doctor to prescribe less than a month's supply (for example, when you are trying a new medication that is known to have side effects). If your doctor agrees to prescribe less than a month's supply for drugs in copayment tiers (Tiers 1 and 2), your copayment can be reduced to a daily cost-sharing copayment. It works like this: your monthly copayment amount for the drug would be divided by the number of days' supply for a month and then multiplied by the number of actual days that you receive. If you later fill the remainder of that month's supply, your remaining cost would also be prorated so that you don't pay more than one month's copayment for a month's supply of drugs. Daily cost-sharing allows you to make sure a drug works before you pay for a whole month's supply.

NOTE: Daily cost-sharing doesn't apply to coinsurance tiers (Tiers 3 and 4) since the coinsurance percentage is already based on the total cost of the drug, whether it's for 34 days or less.

Coverage Gap Stage – Once your total drug cost (the amount paid by you and the plan) exceeds $2,850, you move from the Initial Coverage Stage into the Coverage Gap Stage, and the way that your claim is paid changes. You get the benefit of the Medicare Coverage Gap Discount Program, which pays 50% of the cost of any covered brand drug manufactured by a program participant. This means that:

- Plan costs are further reduced by the discount.
- The amount that participants pay in copayment/coinsurance PLUS the amount paid by the discount program will count toward reaching the Catastrophic Coverage Stage.
- If the balance of the drug cost after the discount is less than the coinsurance due based on the coverage tier of the drug, you will pay less than you paid in the Initial Coverage Stage.

Health Care Reform requires that in 2014, beneficiaries pay no more than 47.5% of the cost of brand drugs in the Coverage Gap Stage. While generic drugs are not a part of the Medicare Coverage Gap Discount program, your cost for generic drugs will be no more than 72% in this stage. In most cases, this plan provides a greater benefit.

Catastrophic Coverage Stage – In 2014, if your annual true out-of-pocket drug expense (including deductible, copayments, coinsurance, and the contribution from the Medicare Coverage Gap Discount Program, but not including the cost of non-covered or excluded drugs) reaches $4,550, you will pay the greater of either 5% coinsurance or a copayment of $2.55 (generics or drugs treated as generics) or $6.35 (brand-name drugs). You will remain in this stage for the remainder of the year.

Your Medicare Explanation of Benefits (EOB) – To help you track your coverage stages, you will receive an EOB directly from Express Scripts for any months during which you use your benefit.

Notice of Creditable Coverage – The outpatient prescription drug coverage that is available through the State Retiree Health Benefits Program to its Medicare-eligible retiree group participants is a Medicare Part D plan and, therefore, creditable coverage. As such, a Notice of Creditable Coverage is not required. However, beneficiaries will not have to pay a higher premium for any period during which they are enrolled in this plan if they decide later to enroll in other Medicare Part D coverage, as long as there is not a break in creditable coverage of 63 or more days.

Enrolling in Part D Plans Outside of the State Program – Your enrollment in Medicare prescription drug coverage outside of the state program will result in your disenrollment from the state program's Medicare Part D plan. If you do not notify the state program of your other election, Medicare will do so. **Once you have enrolled in Medicare Part D coverage outside of the state program, you may not re-enroll in the state program's Part D plan.**

Enrollment in the state's enhanced Medicare Part D plan for outpatient prescription drug coverage is contingent upon approval by the Centers for Medicare and Medicaid Services. The State Retiree Health Benefits Program must remove prescription drug coverage from the plan of any participant whom Medicare has advised is not eligible for coverage. This could be due to conflicting coverage in another Medicare Part D plan, loss of eligibility for Medicare, or any reason determined by Medicare. If Medicare disenrolls you from the state program's Medicare Part D plan, you will be moved to either the Advantage 65—Medical Only Plan or the Advantage 65—Medical Only Plan with Dental/Vision (depending on your existing dental/vision enrollment status). There are no medical-only plan options under the Medicare Supplemental/Option II or Medicare Complementary/Option I Plans.

▪ *Is the state program's prescription drug coverage the best plan for me?*

That's a question that only you can answer, but be a good consumer and investigate other Medicare prescription drug plan options for 2014. Compare premium cost and benefits to ensure that you are selecting the best plan to meet your individual needs. The Medicare Annual Coordinated Election Period that runs from October 15 through December 7 is a good time to review your current coverage and compare it to other available options.

Resources available to help you review your options include:

- Call 1-800-MEDICARE or go to www.medicare.gov for information about other Medicare prescription drug coverage or Medicare health plan options.
- Contact the Virginia Department for the Aging Insurance Counseling and Assistance Program (VICAP) at 1-800-552-3402 for assistance with selecting an available plan outside of the state

program. If you live outside of Virginia, resources in your state are listed in your Express Scripts Medicare Evidence of Coverage.

If you find a prescription drug plan that better meets your needs, you can drop your state program coverage prospectively at any time by selecting a medical-only plan. However, once you leave the state program's Medicare Part D plan, you may not return.

Your Options for 2014 – What You Need To Do

If you wish to maintain your current benefit plan, no action on your part is necessary. If you continue to be eligible, your new monthly premium for your current plan will automatically be deducted or billed.

If you wish to make an allowable plan change for January 1, 2014, you must request the change by taking one of the following actions:

- Obtain an enrollment form from your Benefits Administrator (see page 11), or from the web at www.dhrm.virginia.gov and submit your request to your Benefits Administrator no later than December 2, 2013. (Requests received after December 2, 2013, but before January 1, 2014, will be effective on January 1, but there may be a delay in implementing the change and updating your premium.)
- Request changes online no later than December 31, 2013, by using EmployeeDirect at www.dhrm.virginia.gov (click on the EmployeeDirect link).
    - To use EmployeeDirect, you must have a personal e-mail address listed in the state's eligibility system. (A state e-mail address will not allow access to EmployeeDirect for retiree group participants.) If you do not already have an e-mail address in your eligibility file, you may contact your Benefits Administrator to update your record.
    - Your ID number appears on your plan ID cards and is a seven-digit number, which is followed by XU. For EmployeeDirect, use only the seven-digit number, not the three-letter prefix that appears on your Anthem ID card or the XU.
    - NOTE: January 1 changes using EmployeeDirect must be requested during the month of December. If you request an allowable change through EmployeeDirect in November, it will generally become effective on December 1.

Allowable changes requested after December 31, 2013, will be effective the first of the month after the request is received per program policy. **All Enrollment Forms must be signed by the Enrollee (Retiree, Survivor or LTD Participant); forms signed by a covered family member will not be accepted.**

The following options are available to you for January 1:

- **You may keep your current benefit plan as long as you remain eligible (no action required).**

  NOTE: OPTION I ENROLLEES SHOULD REVIEW THE INFORMATION PROVIDED ON PAGES 2-3 AND CONSIDER MAKING A PLAN CHANGE.

- You may make a plan change as follows:
    - You may elect Medical-Only coverage (no outpatient prescription drug coverage). If you drop your prescription drug coverage, you may not elect Medicare-coordinating prescription drug coverage through the state program again in the future.
    - If you are in Advantage 65, Medicare Supplemental/Option II or Advantage 65—Medical Only (and have not previously elected the Dental/Vision option), you may add Dental/Vision coverage one time and terminate it one time. Once you have terminated Dental/Vision coverage, you may not add it again.

- Retirees, Survivors and LTD Participants may cancel a family member's coverage at any time on a prospective basis. However, once family members of a Medicare-eligible participant have been cancelled, they may only be added within 60 days of the occurrence of a consistent qualifying mid-year event (e.g., loss of eligibility for other group coverage) that would allow the addition. Medicare-eligible Enrollees do not have an annual Open Enrollment opportunity. Open Enrollment to increase membership is not available based on non-Medicare-eligible family participants.

- All Medicare-eligible covered family members (e.g., retiree and spouse) may have separate plan elections, but only the Enrollee can request a change.

- State coverage as an Enrollee may be cancelled completely, but you will not have an opportunity to return to the program at any time in the future. This will also result in the cancellation of any covered family members.

NOTE: Medical-Only Plan participants may not enroll in any state-program-sponsored Medicare-coordinating plan that includes outpatient prescription drug coverage.

Other Important Retiree Program Information

▪ *As a Medicare Beneficiary, will my benefits change due to the introduction of the Health Insurance Marketplace?*

You have probably heard about the Health Insurance Marketplace, which is a key part of the Affordable Care Act that will take effect in 2014. Regardless of how you get Medicare (Original Medicare or a Medicare Advantage Plan), you still have the same Medicare benefits you have now, and you won't have to make any changes. If you want additional information about the Marketplace, visit www.HealthCare.gov.

▪ *Can I enroll in a Medicare Advantage Plan?*

The state's Medicare-coordinating plans specifically exclude services or supplies that are received through Medicare Advantage Plans, so enrolling in a Medicare Advantage Plan, if allowed by Medicare, will generally result in loss of benefits under the state program's Medicare-coordinating plans. State program participants may terminate their state program Medicare-coordinating coverage prospectively at any time (no return to the program). If you wish to enroll in a Medicare Advantage Plan, consider cancelling your coverage in the state program. (This would also result in termination of any covered family members.) If you enroll in a Medicare Advantage Plan and do not cancel your state coverage, consider carefully whether you wish to continue paying for coverage that may provide minimal, if any, medical benefits. In some cases, enrollment in a Medicare Advantage plan or other Medicare supplemental coverage could conflict with your state program enrollment. Also, if your Medicare Advantage plan includes prescription drug coverage, it will likely result in your disenrollment from the state program's Medicare Part D plan (no re-enrollment allowed).
Please note that the Advantage 65 Plans are not Medicare Advantage plans.

A new plan year and Medicare enrollment period are good times to review all plan options available to you as a Medicare beneficiary. There could be a plan outside of the state program that better meets your needs, either in benefit, cost level or both. However, be sure that you understand the impact of enrolling in other plans if you still want to keep your state plan coverage. Some things to think about and compare include:

- Premium cost
- Benefits
- Out-of-pocket expenses such as deductible, copayments, or coinsurance
- Drugs covered on the plan's formulary (are your drugs covered?)
- Coverage in the gap or "donut hole" (have you ever had enough total drug cost to reach the donut hole?)

Use the resources listed on page seven to help you make a choice that meets your individual needs. If you have questions about Medicare's rules for conflicting coverage, please contact Medicare.

▪ ***Will I get a new ID card for 2014?***

New cards will only be issued if there is a plan change that requires a change to your existing ID card/cards or you are enrolling in a new plan. Otherwise, you may continue to use your current cards for covered services in 2014. This may include your Medco Medicare Prescription Plan card. Even though the plan name has changed to Express Scripts Medicare, if you still have a Medco Medicare Prescription Plan ID card, it will still work in 2014.

▪ ***Will I get a new Member Handbook for 2014?***

Your January 2011 Medicare-Coordinating Plans Member Handbook was updated online in July 2011 as noted in your printed handbook. A handbook amendment to include this update is available online at www.dhrm.virginia.gov or by calling your Benefits Administrator.

Participants enrolled in a plan that includes Express Scripts Medicare (all plans except the Advantage 65 Medical Only Plans) will find an updated Prescription Drug Insert enclosed. The 2013 version should be discarded after December 31, 2013.

Those Enrollees in the Dental/Vision option will find enclosed an amendment to their handbook insert. This will reflect the change in the vision benefit discussed on page four of this booklet.

▪ ***What resources are available for information about the State Retiree Health Benefits Program?***

In addition to your Benefits Administrator and your Member Handbook (and applicable insert/s), there are many resources available at the Department of Human Resource Management's Web site to provide information to retiree group participants about their State Retiree Health Benefits Program coverage.

Go to http://www.dhrm.virginia.gov/hbenefits/retirees/medicareretiree.html.

▪ ***How does Medicare eligibility prior to age 65 affect program participation?***

When an Enrollee (Retiree, Survivor, LTD participant) or a covered family member becomes eligible for Medicare prior to age 65, an enrollment form should be submitted immediately to elect a Medicare-coordinating plan. While this letter is being directed to Enrollees and/or their family members already enrolled in Medicare-coordinating plans, this information is provided to ensure that other covered family members who may be in non-Medicare plans are also moved to Medicare-coordinating coverage immediately upon eligibility. It is the responsibility of the Enrollee to ensure adherence to this provision. Failure to do so could result in significant coverage deficits.

This is an important provision of the State Retiree Health Benefits Program. All participants who are eligible for Medicare, regardless of age, must enroll in both Parts A and B (Original Medicare) in order to get the full benefit of any state program Medicare-coordinating plan since Medicare becomes the primary payer of claims for those who are no longer covered based on current employment. This also provides an opportunity for enrollment in the state program's Medicare Part D plan as a part of the Advantage 65 or Advantage 65 with Dental/Vision Plan (pending approval by Medicare).

If it is determined that a retiree group participant is eligible for Medicare and has not enrolled in a Medicare-coordinating plan, he or she will be placed in the Advantage 65 with Dental/Vision plan immediately. If participants have declined Medicare coverage, it could result in a delay in enrollment and a critical gap in coverage until Medicare goes into effect. The state program will not pay any claims that should have been paid by Medicare had the participant been properly enrolled in Medicare coverage. The state program tracks Medicare eligibility due to age and can generally identify eligibility prior to age 65, but it is in the best interest of the Enrollee to report eligibility as soon as it is determined.

▪ *What happens if I fail to pay my premium?*

Plan participants are responsible for timely payment of their monthly premiums (either through retirement benefit deduction or by direct payment to the billing administrator). Monthly premiums that remain unpaid for 31 days after the due date will be processed for termination of coverage. Once an Enrollee and his/her family members have been terminated for non-payment of premiums, re-enrollment in the program is at the discretion of the Department of Human Resource Management.

Direct-bill participants may enroll for automatic deduction of their monthly premium from their bank accounts and may make online check payments. Contact Anthem for more information. Participants are responsible for understanding their premium obligation and for notifying the program within 60 days of any qualifying mid-year event that affects eligibility and/or membership level. Premium overpayments due to failure of the Enrollee (Retiree, Survivor, LTD Participant) to advise the program of membership reductions may result in loss of the overpaid premium amount.

▪ *What should I do if my address changes?*

Was this package forwarded to you from an old address? If so, be sure to contact your Benefits Administrator immediately to make an address correction. Failure to update your address can result in your missing important information about your health benefits program. The Department of Human Resource Management will not be responsible for information that participants miss because their address of record has not been corrected. The Department's only means of communicating important information to retiree group enrollees is through the mail. You can update personal information by using EmployeeDirect online (see page eight for more information about EmployeeDirect). Please let your Benefits Administrator know when you move!

▪ *How can I get information about HIPAA Privacy Protections?*

The Office of Health Benefits Notice of Privacy Practice describes how the health plan can use and disclose your health information and how you can get access to this information. Participants can obtain a copy of the privacy notice at www.dhrm.virginia.gov.

▪ *Who is my Benefits Administrator?*

If you have questions about eligibility and enrollment, contact:

If You Are A:	*Contact This Benefits Administrator*
Virginia Retirement System Retiree/Survivor or a VSDP Long Term Disability Program Enrollee	The Virginia Retirement System 1-888-827-3847 www.varetire.org
Local or Optional Retirement Plan Retiree/ Survivor or a non-VSDP LTD participant	Your Pre-Retirement Agency Benefits Administrator
Non-Annuitant Survivor (surviving spouse or child of an employee or retiree—not receiving a VRS benefit)	The Department of Human Resource Management 1-888-642-4414 www.dhrm.virginia.gov